within the commercial health care industry.

Supplier, as used in this subpart only, means a physician or other practitioner, a facility, or other entity (other than a provider) not already governed by or subject to 42 CFR part 136 subpart D, that furnishes items or services under this Subpart.

§ 136.203 Payment for provider and supplier services purchased by Indian health programs.

(a) Payment to providers and suppliers not covered by 42 CFR part 136 subpart D, for any level of care authorized under part 136, subpart C by a Purchased/Referred Care (PRC) program of the IHS; or authorized by a Tribe or Tribal organization carrying out a PRC program of the IHS under the Indian Self-Determination and Education Assistance Act, as amended, Public Law 93–638, 25 U.S.C. 450 *et seq.;* or authorized for purchase under §136.31 by an urban Indian organization (as that term is defined in 25 U.S.C. 1603(h)) (hereafter collectively ''I/T/U''), shall be determined based on the applicable method in this section:

(1) If a specific amount has been negotiated with a specific provider or supplier or its agent by the I/T/U, the I/T/U will pay that amount, provided that such amount is equal to or better than the provider or supplier's Most Favored Customer (MFC) rate, as evidenced by commercial price lists or paid invoices and other related pricing and discount data to ensure that the I/T/U is receiving a fair and reasonable price. The MFC rate limitation shall not apply if:

(i) The prices offered to the I/T/U are fair and reasonable, as determined by the I/T/U, even though comparable discounts were not negotiated; and

(ii) The award is otherwise in the best interest of the I/T/U, as determined by the I/T/U.

(2) If an amount has not been negotiated in accordance with paragraph (a)(1) of this section, the I/T/U will pay the lowest of the following amounts:

(i) The applicable Medicare payment amount, including payment according to a fee schedule, a prospective payment system or based on reasonable cost (''Medicare rate'') for the period in which the service was provided, or in the event of a Medicare waiver, the payment amount will be calculated in accordance with such waiver.

(ii) An amount negotiated by a repricing agent if the provider or supplier is participating within the repricing agent's network and the I/T/U has a pricing arrangement or contract with that repricing agent.

(iii) An amount not to exceed the provider or supplier's MFC rate, as evidenced by commercial price lists or paid invoices and other related pricing and discount data to ensure that the I/T/U is receiving a fair and reasonable price, but only to the extent such evidence is reasonably accessible and available to the I/T/U.

(3) In the event that a Medicare rate does not exist for an authorized item or service, and no other payment methodology provided for in paragraph (a)(1) or (2) of this section are accessible or available, the allowable amount shall be deemed to be 65% of authorized charges.

(b) Coordination of benefits and limitation on recovery: If an I/T/U has authorized payment for items and services provided to an individual who is eligible for benefits under Medicare, Medicaid, or another third party payer—

(1) The I/T/U is the payer of last resort under 25 U.S.C. 1623(b);

(2) If there are any third party payers, the I/T/U will pay the amount for which the patient is being held responsible after the provider or supplier of services has coordinated benefits and all other alternate resources have been considered and paid, including applicable co-payments, deductibles, and coinsurance that are owed by the patient;

(3) The maximum payment by theI/T/U will be only that portion of the payment amount determined under this section not covered by any other payer;

(4) The I/T/U payment will not exceed the rate calculated in accordance with paragraph (a) of this section (plus applicable cost sharing); and

(5) When payment is made by Medicaid it is considered payment in full and there will be no additional payment made by the I/T/U to the amount paid by Medicaid.

(c) Authorized services: Payment shall be made only for those items and services authorized by an I/T/U consistent with this part 136 or section 503(a) of the IHCIA, Public Law 94–437, as amended, 25 U.S.C. 1653(a).

(d) No additional charges:

(1) If an amount has not been negotiated under paragraph (a)(1) of this section, the health care provider or supplier shall be deemed to have accepted the applicable payment amount under paragraph (a)(2) of this section as payment in full if:

(i) The services were provided based on a Referral, as defined in §136.202; or,

(ii) The health care provider or supplier submits a Notification of a Claim for payment to the I/T/U; or

(iii) The health care provider or supplier accepts payment for the provision of services from the I/T/U.

(2) A payment made and accepted in accordance with this section shall constitute payment in full and the provider or its agent, or supplier or its agent, may not impose any additional charge—

(i) On the individual for I/T/U authorized items and services; or

(ii) For information requested by the I/T/U or its agent or fiscal intermediary for the purposes of payment determinations or quality assurance.

(e) IHS will not adjudicate a notification of a claim that does not contain the information required by §136.24 with an approval or denial, except that IHS may request further information from the individual, or as applicable, the provider or supplier, necessary to make a decision. A notification of a claim meeting the requirements specified herein does not guarantee payment.

(f) No service shall be authorized and no payment shall be issued in excess of the rate authorized by this section.

§ 136.204 Authorization by an urban Indian organization.

An urban Indian organization may authorize for purchase items and services for an eligible urban Indian as those terms are defined in 25 U.S.C. 1603(f) and (h) according to section 503 of the IHCIA and applicable regulations. Services and items furnished by physicians and other health care professionals and non-hospital-based entities shall be subject to the payment methodology set forth in §136.203.

Subpart J—Indian Health Care Improvement Act Programs

AUTHORITY: Secs. 102, 103, 106, 502, 702, and 704 of Pub. L. 94–437 (25 U.S.C. 1612, 1613, 1615, 1652, 1672 and 1674); sec. 338G of the Public Health Service Act, 95 Stat. 908 (42 U.S.C. 254r).

SOURCE: 42 FR 59646, Nov. 18, 1977, unless otherwise noted. Redesignated at 67 FR 35342, May 17, 2002.

SUBDIVISION J–1—PROVISIONS OF GENERAL AND SPECIAL APPLICABILITY

§ 136.301 Policy and applicability.

(a) *Policy*. (1) It is the policy of the Secretary to encourage Indians to enter the health professions and to ensure the availability of Indian health professionals to serve Indians. The recruitment and scholarship programs under this subpart will contribute to this objective.

(2) The regulations of this subpart are intended to be consistent with principles of Indian self-determination and to supplement the responsibilities of the Indian Health Sevice for Indian health manpower planning and for assisting Indian tribes and tribal organizations in the development of Indian manpower programs.

(b) *Applicability*. The regulations of this subpart are applicable to the following activities authorized by the Indian Health Care Improvement Act:

(1) The award of health professions recruitment grants under section 102 of the Act to recruit Indians into the health professions (Subdivision J–2);

(2) The award of preparatory scholarship grants and pregraduate scholarship grants under section 103 of the Act, as amended, to Indians undertaking compensatory and preprofessional education (Subdivisions J–3 and J–8);

(3) The award of Indian Health Scholarship grants pursuant to section 338G of the Public Health Service Act (42 U.S.C. 254r) to Indian or other students in health professions schools (Subdivision J–4):